

Hunterian Society

REPORT.

SESSION 1881-82.



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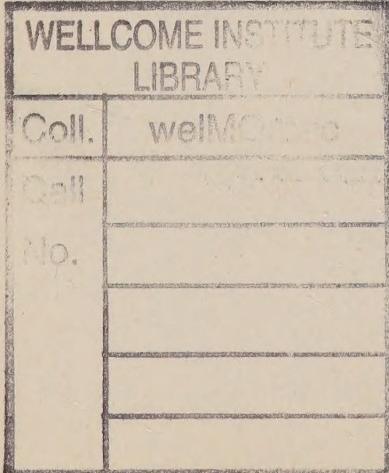
ABSTRACT OF THE TRANSACTIONS
OF THE
HUNTERIAN SOCIETY
SESSION 1881—1882,
WITH
THE REPORT

LIST OF OFFICERS AND MEMBERS.

SOCIETY INSTITUTED FEBRUARY, 1819.

LONDON:
PRINTED BY A. T. ROBERTS, SON & CO., 5, HACKNEY ROAD, E.

1882.



LIST OF PRESIDENTS

FROM THE

FIRST INSTITUTION OF THE SOCIETY.

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|---------------------------------|-----------------------------------|
| SIR WILLIAM BLIZARD. | S. SOLLY, Esq., F.R.S. |
| BENJAMIN ROBINSON, M.D. | W. J. LITTLE, M.D. |
| WILLIAM BABINGTON, M.D. | D. HENRY WALNE, Esq. |
| BENJAMIN TRAVERS, Esq. | SIR JAMES RISDON BENNETT,
M.D. |
| A. BILLING, M.D., F.R.S. | GEORGE CRITCHETT, Esq. |
| THOMAS CALLAWAY, Esq. | THOMAS MEE DALDY, M.D. |
| CHARLES ASTON KEY, Esq. | ALFRED SMEE, Esq., F.R.S. |
| B. GUY BABINGTON, M.D., F.R.S. | STEPHEN H. WARD, M.D. |
| BRANSBY B. COOPER, Esq., F.R.S. | JOHN JACKSON, Esq. |
| JOHN WHITING, M.D. | THOMAS BEVILL PEACOCK,
M.D. |
| JOHN SCOTT, Esq. | JONATHAN HUTCHINSON, Esq. |
| WILLIAM COOKE, M.D. | D. DE BERDT HOVELL, Esq. |
| JAMES LUKE, Esq. | HERBERT DAVIES, M.D. |
| RICHARD BRIGHT, M.D., F.R.S. | THOMAS BRYANT, Esq. |
| G. W. MACMURDO, Esq., F.R.S. | ROBERT BARNES, M.D. |
| F. H. RAMSBOTHAM, M.D. | W. SEDGWICK SAUNDERS, M.D. |
| EDWARD COCK, Esq. | H. I. FOTHERBY, M.D. |
| H. MARSHALL HUGHES, M.D. | A. E. DURHAM, Esq. |
| JOHN ADAMS, Esq. | T. B. CROSBY, M.D. |
| HENRY GREENWOOD, M.D. | J. BRAXTON HICKS, M.D., F.R.S. |
| JOHN HILTON, Esq., F.R.S. | JOHN COUPER, Esq. |
| J. C. W. LEVER, M.D. | P. L. BURCHELL, M.B. |
| T. B. CURLING, Esq., F.R.S. | |
| G. H. BARLOW, M.D. | |

OFFICERS
OF THE
HUNTERIAN SOCIETY,
For the Session 1882—83.

President.

J. HUGHLINGS JACKSON, M.D., F.R.S.

Vice-Presidents.

J. E. ADAMS, Esq.	M. BROWNFIELD, Esq.
F. GORDON BROWN, Esq.	WAREN TAY, Esq.

Treasurer.

H. I. FOTHERBY, M.D.

Trustees.

H. I. FOTHERBY, M.D.	D. DE BERDT HOVELL, Esq.
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Librarian.

P. L. BURCHELL, M.B.

Orator.

E. G. GILBERT, Esq.

Secretaries.

R. CLEMENT LUCAS, B.S.	G. E. HERMAN, M.B.
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Council.

T. E. BOWKETT, Esq.	ALEX. GRANT, M.A., M.D.	H. PORT, M.D.
C. DAVIDSON, Esq.	E. G. GILBERT, Esq.	W. RIVINGTON, M.S.
W. J. DICKSON, M.D.	W. T. KING, Esq.	G. J. B. STEVENS, Esq.
E. DUKES, Esq.	STEPHEN MACKENZIE, M.D.	R. M. TALBOT, Esq.

Auditors.

G. LICHTENBERG, M.D.	J. E. ADAMS, Esq.
WAREN TAY, Esq.	STEPHEN MACKENZIE, M.D.

Library Sub-Committee.

JAMES GREENWOOD, M.D.	WALTER RIVINGTON, M.S.
GEORGE ROPER, M.D.	W. C. TOULMIN, Esq.
A. H. SMEE, Esq.	

Stewards for 1882.

BARNES, R., M.D.	FOWLER, R., M.D.	ROPER, G., M.D.
BEACH, FLETCHER, M.B.	GRANT, DUNDAS, M.D.	STEVENS, G. J. B., Esq.
BOWKETT, T. E., Esq.	HICKS, J. BRAXTON, M.D.	SMEE, A. H., Esq.
BROWNFIELD, M., Esq.	HOVELL, D. De B., Esq.	TOULMIN, W. C., Esq.
BURCHELL, P. L., M.B.	LICHTENBERG, G., M.D.	THORP, H. J., Esq.
BURTON, W., Esq.	LITTLE, W. J., M.D.	WALLACE, F., Esq.
CORNER, F. M., Esq.	MACKENZIE, S., M.D.	WALLACE, R. U., M.B.
DUKES, E., Esq.	PHELPS, W., Esq.	WELCH, C., Esq.
DURHAM, A. E., Esq.	PYE-SMITH, P. H., M.D.	WILLIAMSON, J., M.D.
FENWICK, B., M.D.	PORT, H., M.D.	YARROW, G. E., M.D.

Collector.

CHARLES GORDELIER, 25, Devonshire Road, Hackney, N.

SIXTY-THIRD
ANNIVERSARY MEETING,

Wednesday, February 8th, 1882.

P. L. BURCHELL, M.B., President, in the Chair.

THE Secretary having read the Report of the Council, it was

RESOLVED:—

I.—That the Report be received, printed, and circulated amongst the Members.

II.—That the thanks of the Society be presented to the President for his valuable services during the year.

III.—That the thanks of the Society be presented to the Vice-Presidents, the Treasurer, and the Librarian for the zealous performance of their duties.

IV.—That the thanks of the Society be given to the Council, Secretaries, and Auditors.



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HONORARY MEMBERS.

Professor Richard Owen, F.R.S. British Museum, W.C.
Baron Paul Dubois Paris.

ORDINARY MEMBERS.

* Life Members by Purchase, in accordance with Rule LIX.

** Life Member by the Payment of Twenty-five Annual Subscriptions, in accordance with Rule LX.

(C) Members of Council.

When
Admitted.

- 1869 Adams, James E., Esq., Vice-President, Surgeon to the London Hospital, Assistant Surgeon to the Royal London Ophthalmic Hospital, Moorfields, and Consulting Surgeon to the British Orphan Asylum, 17, *Finsbury circus*, E.C.
- 1856 **Allingham, W., Esq. Surgeon to St. Mark's Hospital, 25, *Grosvenor-street*, W.
- 1872 Arthur, Joseph, Esq. 404, *Commercial-road*, E.
- 1864 Bader, Charles, Esq. Ophthalmic Surgeon and Lecturer on Diseases of the Eye at Guy's Hospital, 10, *Finsbury-circus*, E.C.
- 1874 Barlow, Robert, Esq. *Norfolk House, Albion-road, Dalston, N.*
- 1854 **Barnes, Robert, M.D., late President, Obstetric Physician to, and Lecturer on Obstetric Medicine at, St. George's Hospital, 15, *Harley-street*, W.
- 1875 Beach, Fletcher, M.B., Medical Superintendent, Darenth Asylum, Dartford
- 1837 **Bennett, Sir J. Risdon, M.D., F.R.S., late President, Consulting Physician to St. Thomas's Hospital, 22, *Cavendish-square*.
- 1860 Berry, H. T., Esq. 29, *Amwell-street*, E.C.
- 1854 **Blackman, Charles T., Esq. 4, *Highbury-grove*, N.
- 1848 **Blackmore, James Thomas, Esq... 21, *Douglas-road*, *Canonbury*, N.

When
Admitted.

- 1875 Blewitt, Byron, Esq. 120, *Leadenhall-street, E.C.*
- 1882 Bothamley, W. P., Esq. 28, *Cadogan - terrace, South Hackney, E.*
- 1876 Bowkett, Thos. E., Esq. (C) ... 239, *East India-road, E.*
- 1865 Brown, Frederick Gordon, Esq., Vice-President, 16, *Finsbury-circus, E.C.*
- 1865 Brownfield, Matthew, Esq., Vice-President, Surgeon to the Poplar Hospital, 171, *East India-road, Poplar, E.*
- 1882 Bruce, Robert, jun., Esq. 70, *Old-street, E.C.*
- 1862 Bryant, Thomas, Esq., late President, Surgeon to, and Lecturer on Surgery at, Guy's Hospital, 53, *Upper Brook-street, W.*
- 1871 Buncombe, C. H., Esq... ... Resident Medical Officer, City of London Union Infirmary, *Bow-road, E.*
- 1848 **Burchell, Peter Lodwick, M.B., late President, Librarian, 2, *Kingsland road, Shoreditch, E.*
- 1880 Burton, W., Esq. 79, *New North-road, N.*
- 1880 Carrington, R. E., M.D., Demonstrator of Anatomy at Guy's Hospital, 4, *St. Thomas's-street, S.E.*
- 1858 Clapton, E., M.D., late Physician to St. Thomas's Hospital, 10A, *St. Thomas's-street, S.E.*
- 1864 Clapton, W., Esq. 30, *Queen-street, Cheapside, E.C.*
- 1832 **Cock, Edward, Esq., late President, Consulting Surgeon to Guy's Hospital, *Dean-street, St. Thomas's-street, S.E.*
- 1855 **Conolly, C. Thomas, Esq. 3, *Church - hill - villas, Wood-green, N.*
- 1848 **Cooke, Robert Humphreys, Esq... *Church-st., Stoke Newington, N.*
- 1839 **Cooke, William Martin, M.D. ... 3, *Lee-place, Upper Clapton, N.*
- 1858 Corner, F. M., Esq. Surgeon to the Poplar Hospital, *Manor House, East India-road, E.*
- 1882 Cotman, J. S. E., Esq. 140, *Minories, E.*
- 1862 Couper, John, Esq., late President, Surgeon to the London Hospital, 80, *Grosvenor-street, W.*
- 1841 **Critchett, George, Esq., late President, Surgeon to the Royal London Ophthalmic Hospital, 21, *Harley-street, W.*
- 1854 **Crosby, Thomas B., M.D., late President, 21, *Gordon-square, W.C.*
- 1833 **Curling, Thomas Blizzard, Esq., F.R.S., late President, Consulting Surgeon to the London Hospital, 39, *Grosvenor-st., W.*
- 1843 *Dale, George Thomas, Esq. 8, *Pembridge-place, Bayswater, W.*
- 1867 Davidson, Charles, Esq. (C) 29, *Cassland - road, South Hackney, N.*

When
Admitted.

- 1845 **Davies, Herbert, M.D., late President, Consulting Physician to the London Hospital, 23, *Finsbury-square*, E.C.
- 1879 Davies, John, Esq. 69, *New North-road*, N.
- 1878 Dickson, W. J., M.D. (C) 23, *The Grove, Mare - street, Hackney*, N.
- 1857 Dukes, E., Esq. (C) 52, *Marquess-road, Canonbury*, N.
- 1858 Durham, A. E., Esq., late President, Surgeon to, and Lecturer on Surgery at, Guy's Hospital, 82, *Brook-street, Grosvenor-square*, W.
- 1872 Fendick, Thomas Rowing, Esq. . . 52, *Fore-street*, E.C.
- 1881 Fenwick, Bedford, M.D. 6, *West - street, Finsbury circus*, E.C.
- 1877 Forbes, D. M., Esq. 204, *Hoxton-street*, N.
- 1854 **Fotherby, Henry I., M.D., Treasurer, late President, Physician to the Metropolitan Free Hospital, 3, *Finsbury-square*, E.C.
- 1854 **Fowler, Robert, M.D., Orator .. 12, *Old Burlington-street*, w.
- 1875 Galabin, Alfred L., M.D. . . . Assistant Obstetric Physician to Guy's Hospital, 14, *St. Thomas's-street*, S.E.
- 1876 Gilbert, Edward G., Esq. (C) . . 234, *Mare-street, Hackney*, N.
- 1877 Goodsall, D. H., Esq. 7, *Portland-place*, w.
- 1862 Gowlland, Peter Y., Esq. Surgeon to St. Mark's Hospital, 34, *Finsbury-square*, E.C.
- 1875 Grant, Alexander, M.A., M.D. (C) 370, *Commercial-road*, E.
- 1877 Grant, J. D., M.A., M.B., M.C... 523, *Commercial-road*, E.
- 1863 Greenwood, James, M.D., Vice-President, 48, *Canonbury-square, Islington*, N.
- 1862 Greenwood, Major, M.D. 26, *Queen's-road, Dalston*, E.
- 1882 Greenwood, Arthur, Esq. 178, *Cold Harbour - lane, Camberwell*, S.E.
- 1875 Herman, George Ernest, M.B., Secretary, Assistant Obstetric Physician to the London Hospital, Physician to the Royal Maternity Charity, 7, *West - street, Finsbury circus*, E.C.
- 1853 **Hess, Augustus, M.D. Physician to the Jews' Hospital, Norwood, 14, *City-road*, E.C.
- 1862 Hicks, G. B., Esq. 149, *Amhurst-road, Hackney*, N.
- 1860 Hicks, John Braxton, M.D., F.R.S., late President, Obstetric Physician to, and Lecturer on Obstetric Medicine at, Guy's Hospital, 24, *George-street, Hanover-square*, W.
- 1874 Hopkins, Alfred Boyd, Esq... . . 180, *Shoreditch*, E.

When
Admitted.

- 1850 *Hovell, D. De Berdt, Esq., co-Trustee, late President, Surgeon to the London Orphan Asylum, *Five Houses, Clapton, N.*
- 1862 Humphreys, Thomas B., Esq. .. 19, *Trinity-square, Tower-hill, E.*
- 1855 **Hutchinson, Jonathan, Esq., late President, Senior Surgeon to the London Hospital, 15, *Cavendish-square, W.*
- 1877 Ilott, James John, Esq. Whitechapel Union Infirmary, *Baker's-row, E.*
- 1862 Jackson, J. Hughlings, M.D., F.R.S., President, Physician to the London Hospital, 3, *Manchester-square, W.*
- 1866 Jones, Walter, M.D. 45, *Finsbury-square, E.C.*
- 1881 Keen, Edward, Esq. 44, *New Broad-street, E.C.*
- 1871 King, William T., Esq. (C) 74, *Victoria Park-road, E.*
- 1877 Knox, John, M.D., M.C. Bethnal Green Workhouse Infirmary, E.
- 1860 Lichtenberg, G., M.D. Surgeon to the German Hospital, 47, *Finsbury-square, E.C.*
- 1863 *Little, L. S., Esq. Late Surgeon to the London Hospital, 18, *Park-street, W.*
- 1834 **Little, W. J., M.D., late President, late Physician to the London Hospital, 18, *Park-street, W.*
- 1874 Lucas, R. Clement, B.S., M.B., Secretary, Senior Assistant Surgeon to, and Demonstrator of Operative and Practical Surgery at, Guy's Hospital, 18, *Finsbury-square, E.C.*
- 1876 Mackenzie, Stephen, M.D. (C) .. Physician to, and Lecturer on Medicine at, the London Hospital, 26, *Finsbury-square, E.C.*
- 1869 McCarthy, Jeremiah, M.B., Surgeon to, and Lecturer on Physiology at, the London Hospital, 15, *Finsbury-square, E.C.*
- 1866 Miller, John, M.D... Medical Superintendent, Bethnal House Asylum, E.
- 1850 **Miller, C. M., M.D. 86, *Stoke Newington-road, N.*
- 1880 Moon, Henry, Esq... 26, *Finsbury-square, E.C.*
- 1868 Moxon, Walter, M.D., Physician to, and Lecturer on Medicine at Guy's Hospital, 6, *Finsbury-circus, E.C.*
- 1841 **Munk, William, M.D. Physician to the Small Pox Hospital, and to the Tower Hamlets Dispensary, 40, *Finsbury-square, E.C.*
- 1837 **Oldham, Henry, M.D. Consulting Obstetric Physician to Guy's Hospital, 4, *Cavendish-place, W.*

When
Admitted.

- 1845 **Peacock, Thomas Bevill, M.D., late President, Senior Physician to, and Lecturer on Medicine at, St. Thomas's Hospital, and Consulting Physician to the City of London Hospital for Diseases of the Chest, Victoria Park, 20, *Finsbury circus*, E.C.
- 1864 Pettifer, E. H., Esq. *Southgate-road*, N.
- 1880 Phelps, W., Esq. *Church End, Finchley*.
- 1881 Poland, John, Esq. North East Hospital for Children *Hackney-road*.
- 1875 Port, H., M.D. (C) Physician to the German Hospital, 48, *Finsbury-square*, E.C.
- 1844 **Ponder, William, Esq. *Hayes Cottage, Dulwich-road, Brixton*, S.E.
- 1881 Potter, George W., M.D. 12, *Grosvenor-road*, N.
- 1832 **Pye-Smith, Ebenezer, Esq. *St. Katherine's Lodge, Sevenoaks*
- 1870 Pye-Smith, P. H., M.D. Senior Assistant Physician to, and Lecturer on Physiology at, Guy's Hospital, 56, *Harley-street*, W.
- 1851 **Ramskill, J. Spence, M.D. Consulting Physician to the London Hospital, 5, *St. Helen's-place*, E.C.
- 1875 Rasch, A. A. F., M.D., Physician for Diseases of Women at the German Hospital, 7, *South-street, Finsbury*, E.C.
- 1839 **Rees, G. Owen, M.D., F.R.S. ... Consulting Physician to Guy's Hospital, 26, *Albemarle-street*, W.
- 1869 Reeves, H. A., Esq. Assistant Surgeon to the London Hospital, 8, *Grosvenor-street*, W.
- 1866 Rivington, Walter, M.B., M.S. (C), Surgeon to, and Lecturer on Anatomy at, the London Hospital, 22, *Finsbury-square*, E.C.
- 1855 **Roper, George, M.D. Consulting Physician to the Royal Maternity Charity, 7, *Queen Anne-street*, W.
- 1853 **Saunders, W. Sedgwick, M.D., F.S.A., late President, Medical Officer of Health for the City of London, 13, *Queen-street, Cheapside*, E.C.
- 1875 Sequeira, H. L., Esq. 34, *Jewry-street, Aldgate*, E.
- 1842 **Sewell, Charles Brodie, M.D. ... 21, *Cavendish-square*, W., and 13, *Fenchurch-street*, E.C.
- 1842 **Shaw, Henry, Esq. 144, *Bishopsgate st. Without*, E.C.
- 1854 **Shillitoe, Buxton, Esq. Surgeon to the Lock Hospital, 2, *Frederick-place, Old Jewry*, E.C.
- 1881 Slimon, William, M.B., M.C. ... 4, *York-place, Bow-road*, E.

When
Admitted.

1869	Smee, Alfred H., Esq.	<i>The Grange, Hackbridge, Surrey</i>
1881	Smith, Gerard H.	<i>Glenarme House, Upper Clapton.</i>
1881	Steele, Richard, Esq.	North East Hospital for <i>Children, Hackney-road.</i>
1875	Stevens, George J. B., Esq. (C) ..	<i>Wadhurst House, Newington-green, Stoke Newington, N.</i>
1869	Stewart, Alexander, Esq.	<i>112, Cheapside, E.C.</i>
1850	**Sutro, Sigismund, M.D.	Physician to the German <i>Hospital, 37A, Finsbury-square, E.C.</i>
1864	Sutton, Henry G., M.B.	Physician to the London <i>Hospital, 9, Finsbury-square, E.C.</i>
1880	Symonds, C. J., M.S., M.B.. . .	Assistant Surgeon and Surgical Registrar to Guy's Hospital, 15, <i>St. Thomas-street, S.E.</i>
1878	Talbot, R. M., Esq. (C)	<i>Clarendon-house, Bow-road, E.</i>
1879	Tatham, R. O., Esq.	<i>1, Montague-place, Poplar.</i>
1869	Tay, Waren, Esq., Vice-President, Surgeon to the London Hospital, 4, <i>Finsbury-square, E.C.</i>	
1882	Thomas, G. H. W., Esq.	<i>79, New North-road, N.</i>
1879	Thomson, H. Warnford, Esq. . . .	<i>26, Mildmay-road, N.</i>
1880	Thorp, Henry J., Esq.	<i>17, Southwark-bridge-road, S.E.</i>
1867	Thyne, Thomas, M.D.	<i>140, Minories, E.</i>
1869	Toulmin, W. C., Esq.	<i>Upper Clapton, N.</i>
1881	Treves, Frederick, Esq.	<i>18, Gordon-square, W.C.</i>
1878	Turner, F. Charlewood, M.D. . .	Assistant Physician to the London Hospital, 15, <i>Finsbury-square, E.C.</i>
1857	Wallace, R. U., M.B.	<i>1, Evering-villas, Amhurst-road,</i> <i>Hackney, N.</i>
1878	Wallace, Frederick, Esq.	<i>243, Hackney-road, E.</i>
1876	Welch, C., Esq.	<i>377, Hackney-road, E.</i>
1877	Welch, Samuel, Esq.	<i>157, Victoria Park-road.</i>
1878	Weller, George, Esq.	<i>Forest Lodge, Wanstead, E.</i>
1874	Wells, H., Esq., H.B.M. Vice-Consul, <i>Gualequaychie, Entre Rios,</i> <i>South America.</i>	
1876	White, J. B., M.D..	<i>Homerton Union, N.</i>
1864	Williamson, James, M.D.	<i>44, Mildmay-park, N.</i>
1882	Worley, William C., Esq.	<i>Brooke Lodge, De Beauvoir rd., N.</i>
1880	Yarrow, G. E., M.D.	<i>87, Old-street, E.C.</i>

CORRESPONDING MEMBERS.

Assaid, Said	<i>Beyrout.</i>
Barnes, Thomas, M.D.	<i>Carlisle.</i>
Blest,—, M.D.	<i>Valparaiso.</i>
Bonparola, Professor	<i>Naples.</i>
Butler, Cornelius, Esq.	<i>Brentwood.</i>
Butler, Frederick, Esq.	<i>Winchester.</i>
Colson, Al., M.D...	<i>Noyon.</i>
Curling, Henry, Esq.	<i>Ramsgate.</i>
Dupau, A., D.C.	<i>Paris.</i>
Elkington, George. Esq.	<i>Birmingham.</i>
Fossatti, J., M.D.	<i>Pavia.</i>
Giampetro, Ferdinando, M.D.	<i>Naples.</i>
Gill, John B., Esq.	<i>Dover.</i>
Gorboyne, Alexander, Esq.	<i>Barbadoes.</i>
Gwynn, Thomas, Esq.	<i>Ramsey, Isle of Man.</i>
Märques, Senor	<i>Lisbon.</i>
Martinet, L., M.D.	<i>Paris.</i>
Middlemore, Richard, Esq.	<i>Birmingham.</i>
Mütter, Professor	<i>Philadelphia.</i>
Radford, Thomas, M.D.	<i>Manchester.</i>
Roberts, Alfred, Esq.	<i>Sydney, New South Wales.</i>
Roberts, Bransby B., Esq.	<i>Eastbourne.</i>
Rumball, James Q., Esq.	<i>Harpenden, Herts.</i>
Treves, William Knight.	<i>Margate.</i>
Thornhill, J. H., Esq.	<i>Willenhall, Staffordshire.</i>
Valentine, Professor	<i>Nancy.</i>

*N.B.—Written Communications on Medical Subjects and Donations of
Books will be thankfully received.*

SIXTY-THIRD ANNUAL REPORT.

The Council of the Hunterian Society has much pleasure in presenting to the Members the Sixty-third Annual Report. In doing so, the Council feels able to state that the Society has been as prosperous as heretofore, and as useful in promoting mutual instruction and the free interchange of opinions among its Members.

The Subjects brought before the Society have been various, and the Papers by which they were introduced, of great interest and value; whilst pleasant and unrestricted discussion has been at all times encouraged by the genial courtesy and consideration of the President.

Since the last Report the Society has had to lament the loss of three of its oldest Members. Dr. BILLING, F.R.S., a former Orator and President, was a Physician to the London Hospital, and was the first to give a regular course of clinical lectures in the Metropolis. He was a Member of the Senate of the University of London and of many learned Societies. Mr. LUKE, F.R.S., a former President, was for many years Surgeon to the London Hospital. He was at one time President of the Royal College of Surgeons, and will be remembered in surgery as advocating the operation for hernia without opening the sac. Dr. KINGSFORD practised for many years in Clapton. He served the Society by his presence on the Council, and was much respected by all who knew him.

The Auditors have examined the accounts and find that there is a balance of £27 9s. 1d. in the hands of the Treasurer, and that the funded property amounts to £200.

The Library Sub-Committee has inspected the books, which were found to be correct in number and in a good state of preservation.

HUNTERIAN SOCIETY.

TREASURER'S REPORT FOR 1881-82.

RECEIPTS.

	£ s. d.	£ s. d.
By Balance in hand ..	8 19 2	To Purchase of Books ..
," Subscriptions ..	95 11 0	," Subscription to Lewis' Library ..
," Dividends ..	5 17 3	," Insurance ..
		," Printing, including the Report, Cards, Lists,
		," Notices, &c. ..
		," Minute Book and Stationery ..
		," Oak Cabinet for Society's Books and Papers ..
		," Mr. Williams, Assistant Librarian ..
		," Wickenden, Laboratory Assistant ..
		," Clift, £2. 2. 0.; Mr. Shudwick, £2. 2. 0.
		," Housekeeper's Gratuity ..
		," Refreshments, Tea, Coffee, &c. ..
		," Dinner Tickets for invited Guests ..
		," Collectors' Commission and Expenses ..
		," Balance in hand
	<hr/>	<hr/>
	£110 7 5	£110 7 5

AUDITORS' REPORT.—We, the undersigned, having examined the foregoing Accounts, together with the vouchers, find a balance of £27 9s. 1d. due to the Society, and that the funded property amounts to £200.

(Signed) JAMES E. ADAMS.
STEPHEN MACKENZIE, M.D.
WAREN TAY.

January 6th, 1882.

SESSION 1881-82.

A Meeting of the Hunterian Society was held at the London Institution, on Wednesday, February 23rd, 1881, Dr. P. L. BURCHELL, President, in the Chair.

The PRESIDENT briefly expressed to the Meeting his sense of the honour done him in his election to the Presidential chair, and his desire to efficiently fulfil the duties of his office.

MR. G. J. B. STEVENS read notes of a case of "*gangrenous erysipelas of the scrotum and penis.*" The patient, aged 23, had been generally healthy, but had always had a rather tight foreskin. After having slight irritation and swelling of the prepuce during two weeks, consequent upon marriage, he became unfit for work, and came under Mr. Stevens's notice on November 23rd, 1880. He then had slight balanitis with phimosis and oedema of the prepuce and penis. The parts could be by pressure relieved of fluid just enough to allow, by forcible retraction, a sight of the glans. He was ordered the recumbent posture, and lead lotion applied on wrappings externally, and syringed under the prepuce. Nov. 24th. — There was a slight dark blue spot on the prepuce, and the swelling had extended to the right side of the scrotum. The foreskin was slit up. Nov. 25th. — The whole scrotum was becoming infiltrated, and on the left side

getting hard and brawny. The livid spot on the prepuce was extending. In the evening free incisions into the scrotum and penis were made by Mr. Lucas. Sanious fluid and blood oozed freely from the incisions. In a week from this date, several extensive sloughs separated, but no untoward symptoms arose, except the formation of an abscess in the left groin, which was opened. Loss of skin occurred on the penis only, the wounds on the scrotum becoming linear scars.

The case had been mentioned in the advertisement of the meeting, as one of "idiopathic" erysipelas, &c. Mr. Stevens took exception to this view.

Mr. Corner agreed with Mr. Stevens that the disease was not idiopathic, but due to contusion, irritation, and retained secretions. He thought that a lotion of chloride of zinc or carbolic acid, or continuous immersion in a warm bath, might perhaps have checked the disease.

Mr. Lucas admitted that the word "idiopathic" did not apply here. Cases of the kind were rare, and were interesting because they superficially resembled extravasation of urine. He had seen cases at Guy's, in which the perineum had been incised and the urethra opened, but no stricture was found present. He narrated one such case. The chief diagnostic point was, that the swelling and redness were not confined to the parts affected in extravasation of urine, but extended over the thighs and buttocks. Fissure of the rectum was sometimes the starting point of the disease. There was often albuminuria. The local treatment was the same as for extravasation of urine, except that the urethra need not be cut into.

Dr. Mackenzie remarked that cases of Bright's disease were very prone to erysipelas, which was in them very

dangerous. But such cases were not idiopathic. He understood "idiopathic" to mean, that a disease was the sole morbid condition present, and had arisen without discoverable cause.

Mr. Adams asked whether erysipelas was ever idiopathic? It often arose from a very slight primary cause. Erysipelas of the penis and scrotum had been described in the St. Bartholomew's Hospital reports, under the name of "inflammatory oedema of the scrotum." An important point in the diagnosis between this condition and extravasation of urine, was, that in the former, urinous smell was quite absent. The two conditions closely resembled one another in appearance. He had seen one case in which the erysipelas spread over the trunk and the patient died; in this case there was ulceration of the rectum.

The President remarked on the great importance of the question whether the disease was or was not idiopathic.

Mr. STEVENS said that in his case the diagnosis was quite clear, for there was no stricture and no swelling of the perineum. This disease must not be confounded with that form of gangrene of the entire genitals, which has occasionally been known to follow severe adynamic fevers, and which has been described by Partridge, (Med. Times and Gazette, vol. XX).

Mr. JAMES ADAMS read a paper on "*Diphtheritic ophthalmia*," based upon two cases of the typical form of the disease. He stated that the descriptions of it ordinarily found in text books, were for the most part taken from cases seen abroad, it being somewhat exceptional to meet with it in this country, the two cases described being the only ones that had come under his own care. A form of membranous conjunctivitis of

moderate severity was common enough, in which there was only a moderate amount of swelling, with the formation of a pellicle on the conjunctiva of the lids, which was easily removed and frequently renewed; these cases tending to recovery, whereas the essential feature of the severer form was the solid brawny infiltration of the whole lid and sub-conjunctival tissue of the globe as well, causing chemosis and early destruction of the cornea. The mucous surface of the lid, instead of showing a removable false membrane, was of a pale yellowish colour, mottled with red patches, and in the two cases described, the only false membrane that could be removed was formed on the *outside* of the lid on a part where the epithelium had perished from the extreme tension.

The treatment (local) that had found most favour with oculists of late, had been the free use of a lotion of sulphate of quinine, (gr. iii. ad oz.), introduced by Mr. John Tweedy, who had been led to use it from the fact that that alkaloid had been proved experimentally to check cell proliferation and exudation. For all ordinary cases it was perfectly satisfactory, but the author thought that in the most typically severe cases it was inefficient. Mr. Tweedy had however recorded one case at least of the most severe form treated in this way, that had recovered with very slight damage to the cornea.

No doubt it was difficult to convey an accurate idea of this disease by description alone, but it was of the utmost importance to recognize the disease early, the diagnosis being a little difficult owing to the frequent absence of any recognizable false membrane. The danger of ulceration or sloughing of the cornea was very great, and amongst these cases occurring epidemically abroad, the percentage of eyes completely lost was very large. In

both the author's cases sight was wholly lost, but there was ulceration of cornea when the treatment was commenced. In one of these cases the infiltration of the upper lid was so great that it looked as though there were an abscess in the lid, and the exudation around and behind the globe caused an appreciable amount of proptosis.

Mr. Hovell enquired as to the cause of the diphtheria in these cases? He remarked that diphtheria spread by contact, and referred to the danger run by the medical attendant in such cases. The treatment he preferred was chloride of zinc lotion with free incisions.

Dr. Mackenzie enquired whether these cases had communicated disease to any other persons? At the time that one of Mr. Adams's cases was attending as an out-patient at the London Hospital, Dr. Mackenzie had a patient in the Children's ward of that institution, suffering from diphtheria. Dr. Thorne Thorne had shewn that diphtheria might arise from sewage emanations. Experimental investigations had proved that many contagions increase in virulence as they pass from subject to subject. Hence, if these cases had not communicated the disease, that would not negative the diagnosis. He accepted Mr. Adams's diagnosis.

Mr. Fendick enquired as to the strength of the quinine lotion used, and as to the grounds for the diagnosis of diphtheria?

Mr. Corner asked if the exudation had been examined microscopically, and if the urine had been examined? Albuminuria was frequent in diphtheria, and was probably due to blood taint.

Mr. Gilbert asked what had been the treatment after the quinine lotion proved useless? He had been

successful in the treatment of diphtheria with antiseptic applications, and perchloride of iron internally. The presence of a pellicle was not the first sign of diphtheria. He had seen cases like those referred to by Dr. Mackenzie in connection with Dr. Thorne Thorne's investigations, in which there was no diphtheritic membrane, but the illness was contagious.

Mr. Hovell asked if in Mr. Adams's cases there were the general symptoms of diphtheria? Free purgation early in the disease was a most important point in the treatment of diphtheria.

Mr. Gilbert had found that after antiseptic applications had been used, the pellicle did not reform.

Mr. Higgins remarked on the extreme rarity of these cases. Membranous ophthalmia was common enough, and generally got well whatever treatment was adopted. Warmth and cleanliness were the important points.

Mr. Lucas enquired whether in Mr. Adams's cases there had been originally ophthalmia, or a tendency to ophthalmia, which determined the site of the disease? If so, the diphtheria might have been modified by the mode of its entry into the system. He referred in illustration to scarlatina after surgical operations, which is modified by its mode of entry, and to an outbreak of diphtheria in the obstetric ward at Guy's, which there affected the genital mucous membrane.

Dr. Turner thought that neither cases of diphtheria, nor of erysipelas, could correctly be spoken of as "idiopathic," for neither arose *de novo*, each was caused by a specific poison.

Dr. Herman said that judging from books, diphtheritic inflammation of the genital mucous membrane seemed to be much commoner on the continent than in England.

This might be due to the less perfect hygienic arrangements of continental hospitals, and if so, the fact harmonized with the views of Dr. Thorne Thorne.

Mr. ADAMS said that the sister of one of his patients had mild membranous ophthalmia. The constitutional signs of diphtheria were present in his cases. The urine had not been examined. The lids were on the verge of sloughing, hence he had not thought it well to use stimulating applications. The quinine lotion used was gr. v. ad oz. The membrane was not examined microscopically, but probably, like most such membranes, it contained vegetable fungi. There was no disease in the other eye of either patient. He did not think the diphtheria had been in any way modified by pre-existing conditions.

The President remarked on the value of steel in cases of diphtheria.

A Meeting of the Hunterian Society was held at the London Institution, on March 9th, 1881, Dr. P. L. BURCHELL, President, in the Chair.

Mr. ADAMS narrated the details of a case of "*haemorrhage from the middle meningeal artery*," occurring after an injury received in a railway accident at Dalston Junction. The patient, a young man about 26 years old, was sitting in a second-class carriage with his back to the engine, with one passenger on his right hand between himself and the door. After the shock of the collision, he and his fellow passenger got out of the carriage and walked about three hundred yards to Dalston station. He kept his hand to the left side of his head and

complained of pain there. After giving his name to the railway officials, he proceeded to Broad Street by another train, and then took a cab to the Bank of England where his work was, and walked up to his desk. He was then found to be ill and confused and was taken to an inner room and laid upon the sofa. Here he was seen by Dr. Stephen Mackenzie, who found him cold and inclined to collapse, lethargic and drowsy, but easily roused and obedient to requests to put out his tongue, to move his limbs, &c. Pupils equal and active.

At one o'clock he was much in the same condition, had vomited, but the left pupil was widely dilated and inactive. No special change occurred in his symptoms, but when seen at eight o'clock, his left pupil had resumed its symmetry with the other and both were active. He had passed water, asking for a vessel to do it in. He was now passing into a state of reaction, temperature 100·5, pulse 86 and fuller. At ten o'clock he was seized with convulsions, his breathing became stertorous, his cheeks flapping, and his left pupil was again dilated. When seen, both upper and both lower extremities were quite rigid, hands clenched. It was alleged that his left arm had moved more freely than the right, but when seen, no one-sided symptoms were visible. At 11 p.m., he died. The post mortem revealed a very large haemorrhage between the dura mater and the bone, extending down into the middle fossa of the skull, and a fissure fracture crossing the groove for the middle meningeal artery quite at the extremity of the anterior inferior angle of parietal bone. The skull was of most extraordinary thinness, being in many places no thicker than an ordinary sheet of writing paper. The chief points of interest were, the question as to how the injury arose; (the temporary

dilatation of the left pupil did not afford any reliable information); the complete absence of hemiplegic symptoms with so apparently a one-sided injury, and the remarkable thinness of the bone. There was no probability of its being a fracture by contre-coup, as there was a slight ecchymosis in the scalp on the same side as the fracture and none on the other. There certainly was nothing to indicate during life that trephining would be justifiable, as there was very slight evidence of injury visible, and the fact of *all* his pain being on the left side was not made known until his friend gave evidence at the inquest; nor does it seem probable that it would have saved him, as there was an immense clot in the middle fossa which could not have escaped through a trephine hole.

In answer to the President, Mr. Adams said that the patient travelled in a second-class carriage which was padded.

Mr. Fendick narrated a similar case which he had seen. A man had a fall, got up and went on with his work, then had lunch, and afterwards finished his work. Then walked some distance, lay down and went to sleep. Six hours after the injury he was found to be dead. There was a large one-sided extravasation, and a fracture of the skull, which had evidently taken place by contre-coup, for there was cutaneous ecchymosis on the opposite side.

Dr. Roper mentioned a case in his own practice. A woman fell down one evening, walked home and went to bed; next morning was found to be hemiplegic; died in three days. No marked injury to the scalp was discovered, but there was a large clot between the dura mater and the bone. In such cases he thought trephining was called for. He asked if there was any external injury

in Mr. Adams's case.

Dr. Fowler referred to a case which Mr. Adams had seen with him three years ago. A man fell down and struck his eyebrow, walked to the hospital and had it strapped up. Three or four days after he became comatose, and convulsions and death followed. This patient, two or three times after the injury walked about a mile and a half. On autopsy, a fracture of the orbital plate of the frontal bone and wing of the sphenoid was found. Such cases resembled those described by Abercrombie under the name of "ingravescient apoplexy." Prognosis was often difficult.

Mr. Brownfield remembered a case in which a man fell down a ship's hold, then got on deck and walked to the hospital, a distance of a quarter of a mile. He was sensible for 8 hours afterwards, and then symptoms of compression appeared. He was bled, and recovered consciousness sufficiently to tell where his friends lived. He died 17 hours after the accident. Laceration of the cerebellum was found post mortem, with extravasation over the hemispheres. He wished to hear Mr. Adams's opinion as to the value of blood-letting in these cases.

Mr. Corner recollects a similar case, in which the nature of the injury was diagnosed. The skull was trephined, the clot removed, and the patient recovered. The symptoms in Mr. Adams's case were misleading, those of concussion being absent. He thought trephining ought to be more readily resorted to in such cases. With antiseptic precautions, this operation did not seriously increase the danger. He enquired if the eyes had been examined, and would be glad to hear Mr. Adams's opinion as to trephining in these cases.

Mr. ADAMS remembered Dr. Fowler's case. He

thought it one of meningitis, not of haemorrhage. The symptoms in these cases depended on the rapidity with which the haemorrhage took place. He thought bleeding was not often enough resorted to. He had not tried it in these cases, but if it did no more than give an interval of consciousness, it was of use. The presence, with the coma, of one-sided symptoms, formed the chief indication for trephining. In his case, the signs of external injury were very doubtful during life, and there were no one-sided symptoms. Many of the facts he had mentioned about the case could not be elicited during life, but were only ascertained after death. He made it a rule to examine the eyes in every such case, but had very seldom found injury of the fundus. Nothing was found in this case. The dilatation of the pupil passed off. He doubted if trephining would have done good here, because the blood could not have been got out of the middle fossa of the skull.

Mr. ADAMS also showed a heart with *ulcerative endocarditis* affecting the aortic valve and one flap of the mitral, which had caused multiple emboli, and amongst them emboli of both arteriæ centralis retinæ. As the globes had suppurated from the first, it was thought likely that the emboli might be septic and contain micrococci, a point to be determined by further research.

Dr. HERMAN then read a paper on "*prolapse of the ovaries.*" He first pointed out the importance of studying the simplest cases only, and expressed his opinion that in the literature relating to this subject, this principle had been too much lost sight of. He then read notes of five cases, in each of which an ovary was prolapsed into the pouch of Douglas, and there was no indication of any morbid condition other than this prolapse. He then

remarked on the points suggested by the cases. He believed that the prolapsus was a gradual process, brought about by conditions which favoured yielding of the pelvic floor ; child-bearing, long standing vaginal catarrh, and constipation being among the chief. The characteristic symptoms were dyspareunia and dyschezia, the pain being of considerable duration and often accompanied with nausea. The other symptoms were comparatively trifling, and were such as usually accompanied the slighter degrees of prolapse. He then described the physical signs, and remarked on the importance, from the point of view of prognosis, of separating these cases from similar ones accompanied with oöphoritis. The treatment he recommended, consisted in keeping the bowels rather loose, and placing an elastic ring pessary in the vagina. These measures had given relief in all his cases.

Dr. Galabin was accustomed to treat these cases in the way recommended by the author of the paper. He thought ovarian prolapse was often secondary to prolapse of the uterus, and attached more weight to the position of the uterus than did the author; for if the uterus were put in a position of anteversion, the ovaries would be raised. He thought the author's cases were not all quite simple, for in one there was an erosion of the cervix, and in another, dysmenorrhœa and sterility. It was very difficult to draw a line between prolapsus alone and prolapsus with inflammation, or between congestion and inflammation of the ovary. He thought the oöphoritis was often the primary condition. The limitation of pain to the times of defæcation and of sexual intercourse, was not conclusive of the absence of inflammation ; for inflammation might exist without pain, as shewn by inflammation of the cervix, and by endometritis.

On the motion of Dr. Roper, the discussion was adjourned to the next meeting.

A Meeting of the Hunterian Society was held on Wednesday, March 23rd, 1881, at the London Institution, Dr. P L BURCHELL, President, in the Chair.

Dr. W. Slimon, York Place, Bow Road, E., was elected a member of the Society.

Dr. PORT shewed a patient suffering from disseminated sclerosis.

Dr. Roper resumed the discussion on Dr. Herman's paper. He said there were two classes of cases of ovarian prolapse; one in which the ovaries were large and heavy, and became prolapsed; the other in which the uterus became prolapsed, and dragged down the ovaries. It occurred in women of lax fibre. The ordinary obstetric position, on the left side, was misleading in these cases, because the position of the ovary altered with that of the patient. He asked whether Dr. Herman thought his cases were really free from any other morbid conditions? Prolapse of the ovary was a very intractable condition to treat; relief to symptoms was not *cure*; this disease was like a hernia, it could be pushed up, and kept up by mechanical means, but would descend again when the wearing of a support was left off. The best chance of *cure* was in the occurrence of pregnancy.

The President thought the subject a very important one. He had seen several cases in which he thought the symptoms pointed to this condition. He asked whether excessive sexual indulgence had anything to do with it?

Dr. Fowler asked whether, in intractable cases of this

affection, removal of the ovaries would not be justified ?

Dr. HERMAN said that his cases were not absolutely simple, because there must have been some change in the parts to cause the descent. He had known patients remain well for some time after having left off wearing a pessary, and therefore thought that sometimes mechanical treatment might not only relieve, but cure. It was impossible to say that ovaries might not become prolapsed without any symptoms at all, for if so, the prolapse would not be likely to be discovered. He thought that when the symptoms could be completely relieved by treatment, removal of the ovaries was not called for.

Mr. McCARTHY then made a communication on "*the treatment of varicocele by excision.*" He said that this was a revival of an old practice, Mr. Lister and others having recently adopted it. Varicocele was very common, and was more frequent on the left side. The explanations usually given of this fact,—the different arrangement of the spermatic vein of the left side, the presence of the sigmoid flexure on the left side, the lower position of the left testicle,—seemed to him unsatisfactory. The greater frequency of varicocele on the left side, and the lower position of the left testicle, seemed to him alike due to the better muscular tone of the right side of the body. This was shewn by the fact that in left-handed people the right testis was the lower. The inconvenience caused by a varicocele was not in proportion to its size. But there were cases in which, either from its size or for other reasons,—e.g., a man's wishing to enter the army,—it was desirable to cure it. Mr. McCarthy had done the old operation. But the ligatures caused severe pain; the subcutaneous division of the veins was difficult; extrav-

sation of blood, much inflammation, sometimes deep suppuration, and ulceration of skin, often followed the operation. The patient was usually in bed a fortnight, and the cure was uncertain, the varicocele often returning. The new operation consisted in pinching up a fold of the scrotum with the veins in it, exposing the veins by a longitudinal incision, tying them *en masse* above and below, and then cutting them away between the ligatures. The ligatures were then cut short, a drainage tube put in, and the wound dressed antiseptically. It was necessary to confine the bowels for four or five days after the operation. The advantages of this proceeding were, that it caused no pain, there was no inflammation to speak of, there was no extravasation of blood, the cure was effected in about four days, the steps of the operation were visible, and therefore it was easy, and the cure was effectual.

Mr. James E. Adams said his experience was the same as Mr. McCarthy's. But in two cases in which he had done it, the cure was not so speedy as in Mr. McCarthy's. In one, a very large varix, the antiseptic precautions failed, and this perhaps made recovery tedious; it took fourteen days. In the other it took ten days. He thought an operation was required in severe cases of varicocele, but he had not done the old operation, because the results he had seen in the cases of other surgeons were so unsatisfactory. He had been led to adopt excision by Mr. Annandale's cases of excision of varicose veins of the leg.

Mr. Brownfield thought this operation a great boon. He remarked on the mental depression which varicocele often produced, and enquired whether improvement in this respect had followed the operation. He had never seen a good result from the old operation.

Dr. Roper thought that few varicoceles gave much inconvenience. He enquired as to the influence of varicocele on the testis.

Dr. Herman was much interested in Mr. McCarthy's explanation of the greater frequency of varicocele on the left side. Dr. Champneys had shewn that the pain in pelvic cancer was more commonly felt on the left side, although the new growth had no special proclivity for that side; this he ascribed to a greater sensibility to pain of that side.

Mr. McCARTHY said that the mental depression accompanying varicoceles was not in proportion to their size. It was due to the condition of the central nervous system. He had not seen improvement in this respect follow the operation, and did not recommend it for the relief of such symptoms. Varicocele caused dragging pain, and interfered with the nutrition of the testicle, which became sodden and atrophied. The intertubular lymph spaces became distended with lymph, which, confined within the rigid tunica albuginea, pressed upon the secreting structures and led to their atrophy. The greater sensitiveness of the left side, referred to by Dr. Herman, he thought was due to deficient inhibitory influence.

Mr. Adams said that when he found great mental depression associated with a small varicocele, he inferred that the patient masturbated. That the mental depression was not always due to the varicocele, was shewn by one of his own cases, in which relief followed before the patient could have known whether the varicocele was cured or not.

Mr. Brownfield asked why the veins were ligatured?

Mr. McCARTHY said the lower ligature was absolutely necessary. As to the upper one, the veins, in an old case,

were so thickened that they did not collapse, and hence regurgitation might take place, especially as in the left spermatic vein there were no valves. The usual timidity in ligaturing veins was not warranted, for no bad results followed.

Mr. McCARTHY then narrated a case in which he had recently made a post mortem examination. A boy of 14 was admitted into the London Hospital under the care of Dr. Sutton, with symptoms of intestinal obstruction. He had had five previous attacks of the same kind. There was no tumour to be felt, and the urine was scanty. From these facts it was diagnosed that the obstruction was high up, and probably due to some permanent cause, such for instance as a short mesentery, favouring the occurrence of a twist. At the autopsy, the stomach was found so distended as to fill nearly the whole abdomen, and the duodenum was dilated so that it was bigger than the largest colon. The small intestines were contracted and gathered up into a ball. There was no twist, but an exceedingly short mesentery, which had led to a kink in the bowel, so effectually occluding it, that even when taken out of the abdomen and extended, gas could not be forced past it.

In reply to the President, Mr. McCARTHY said that the stomach contained fluid and gas; and in answer to Dr. Herman, that on the post mortem table, with the abdomen fully laid open, it took half an hour's dissection to find the seat of obstruction; any operation would therefore have been impracticable. Possibly however, puncture of the stomach and liberation of gas might have made it easier.

Mr. ADAMS then made some remarks on "*the excision of varicose veins of the leg.*" He had had a case in which

one large vein was varicose. In such, the old operation was very unsatisfactory. In his case excision was very successful, the patient being perfectly well, and able to do without an elastic stocking. About five or six inches of the vein was excised, in two places. This operation was suitable where one, two, or at most three veins only were varicose. It was easier of performance in the leg than in the scrotum.

Mr. Brownfield enquired the opinion of surgical members as to torsion of arteries and veins as a means of arresting haemorrhage.

Mr. ADAMS had been disappointed with torsion. He used catgut ligatures.

Mr. McCarthy also thought torsion unsatisfactory. The presence of a foreign body in a wound was not of such consequence as was thought. After ligature of an artery, the wound having perfectly healed, he had on microscopic examination found cotton fibres in it.

A Meeting of the Hunterian Society was held at the London Institution, on Wednesday, April 6th, 1881, Dr. P. L. BURCHELL, President, in the Chair.

Mr. Frederick Treves was elected a member of the Society.

Dr. HUGHLINGS-JACKSON exhibited patients suffering from disease of the spinal cord.

1.—A case of “‘over-movement’ of the right arm.” The patient had an injury to the head followed by loss of memory and hemiplegia, and then movements of the right arm which lasted six weeks. Then he was free from movement for seven years. Five years ago, after an

injury, the movements returned and had continued since. No treatment had done any good. Dr. Jackson remarked that there was a destructive lesion in the region of the left corpus striatum. He believed that the "over-movement" was due to unantagonized cerebellar influence. "Over-movement" implied over-expenditure of nerve force. There was a nervous centre somewhere which was continually discharging. As to treatment, two measures had to be considered, amputation of the arm or division of the brachial plexus. He asked whether if either of these were done, the motor impulses would not flow in other channels instead of ceasing, and the man's head turn. He had seen one case in which after an operation of the kind the patient's head did turn. He therefore inclined to recommend division at first of one nerve only, so that the effect might be ascertained.

2.—A case of "*lateral sclerosis, following acute transverse myelitis.*" There was rigidity, increased "knee jerk," (a term which Dr. Jackson preferred to that of "patellar tendon reflex," because it did not imply a theory), extreme foot clonus. Dr. Jackson pointed out that in walking, the patient scraped the toes along the ground instead of putting the heels down first, as is seen in locomotor ataxy.

3.—A case of "*tabes dorsalis.*" The patient had the "lightning pains," ataxic gait, Argyll Robertson's symptom, (contraction of pupil on accommodation, but not to light), absence of knee jerk, "girdle pain."

4.—Another case of "*tabes dorsalis,*" in which there was no ataxy of gait. There were "lightning pains," Argyll Robertson's symptom, and absence of knee jerk.

Dr. PORT read notes of a case of "*disseminated sclerosis,*" exhibited by him at the last meeting of the

Society. A sailor, aged 20, had contracted intermittent fever at Batavia 15 months ago, and since that time suffered from various symptoms referable to spinal disease. The affection was chiefly characterized by an impeded gait, trembling of the parts implicated in voluntary movements, exaggerated tendon reflex, and a peculiar scanning speech. Several specimens of the patient's handwriting from before and after the disease were shewn. Treatment had had no effect on the disease, which for some time had remained stationary.

Dr. Stephen Mackenzie remarked on the resemblance of the movements in the first case to those of athetosis. He mentioned that the patient had found the movements subdued by alcohol, and his taking alcohol for this purpose had engendered a craving for it which had been his moral and social ruin. He had used large doses of other sedatives, but none subdued the movements like alcohol. Curara proved of little benefit. He referred to a case of wry neck in which division of the nerve had been successful. There was much plausibility in the view that the disease in this case was localized in the cerebrum. He explained the effect of alcohol in the case by supposing that it paralysed the centre from which the movements proceeded.

Dr. Jackson mentioned the case of a man who had fits beginning in one hand, with much tremor in that hand, which prevented him from working. Alcohol here so subdued the tremor that it enabled the patient to go on working. The patient exhibited had found the restraint of a splint intolerable. In another case he had had, the pressure of a strap round a limb, which prevented the fits, caused giddiness.

Mr. Lucas thought amputation at the shoulder-joint

would be preferable to division of the nerves, for in the latter case the limb would be useless.

Mr. Rivington thought that if the nerves were cut, the nerve currents would flow somewhere else, perhaps to the other side of the trunk. In a case of torticollis in which he had divided the spinal accessory, movements began in the opposite side of the neck.

Mr. Gilbert suggested that if amputation were performed, constant movement of the flaps might interfere with healing.

Mr. Brownfield asked if counter-irritants had been tried?

Dr. JACKSON thought counter-irritation would be worth trying. In the early stage of locomotor ataxy, he thought the presence of the "lightning" pains and the absence of knee jerk was enough for the diagnosis.

A Meeting of the Hunterian Society was held at the London Institution, on Wednesday, April 20th, 1881, Dr. P. L. BURCHELL, President, in the Chair.

Mr. FREDERICK TREVES read a paper on "*the diagnosis and treatment of scrofulous lymphatic glands,*" of which the following is an abstract.

Scrofula indicates a tendency on the part of the individual to inflammations of a peculiar character. The peculiarities are these,—the process tends to be chronic, to be induced by trifling irritation, and to end in cessation or suppuration rather than in resolution. The inflammatory products are remarkably cellular in character, and contain certain peculiar large cell elements, the vascularity is much diminished, and above all the process is remark-

able by the extent to which it invades lymphatic or lymphoid tissue. The chronicity of scrofulous affections is well known; the marked implication of lymphoid tissue is shewn by the fact that in addition to the gland diseases, many scrofulous affections are at the present time known to arise in adenoid tissue,—*e.g.*, the scrofulous ulcer of intestine, scrofulous bronchitis, pharyngitis scrofulosa, etc., and probably phlectenular ophthalmia. Of the external glands, the cervical are the most commonly affected. This is to be explained not solely by the number of those glands, nor the greater possibility of peripheral irritation, but by the fact that those glands in scrofula are the most commonly affected whose radicles are in connection at the periphery with adenoid tissue. The cervical, bronchial and mesenteric glands are those most usually involved in scrofula, and the greatest amount of adenoid tissue is situated in the mouth and pharynx, in the bronchial mucous membrane, and in the bowel.

There is no physiognomy peculiar to scrofula; the supposed indications of struma are,—when any actual evidence of disease has been eliminated,—the indications merely of what is known as delicate health. There is no line of demarcation between scrofula and mere “quality of constitution,” so called. Scrofula occurs in two different types of delicate children, which types accord somewhat with the old division into the sanguineous and phlegmatic varieties of the disease. The appearances and progress of scrofulous glands were then described. The extent of the morbid changes bears no relation to the size of the affected gland. When several adjacent glands are matted together, it is an indication that they contain pus, although they may not be adherent to the skin or even

to the deeper parts to any extent. The differences between scrofulous gland masses and the masses in lymphadenoma were discussed. All chronic glandular elements in children are not necessarily scrofulous. Resolution or absolute cessation of the process may occur at any time previous to the actual appearance of pus.

Treatment.—The good effect of several measures upon gland disease was pointed out. Local applications are seldom indicated, and are required only in the earlier forms of the more chronic varieties, or in apparently quiescent cases. *Ung. plumbi iodidi* would appear to be the best application. A filiform seton is useful in cases of limited disease where accurate destruction of the gland by suppuration is required. Interstitial injections have been associated with considerable success, and may be used either to produce resolution or suppuration. Excision is most successful in proper cases,—where the gland disease is chronic, limited and quiescent, and where only a few glands are involved and are free from any adhesions. The treatment by subcutaneous laceration and by crushing were described. Scrofulous abscesses should be opened either by actual cautery or by small incision with use of a drainage tube. Free incisions are to be condemned.

Dr. CHARLEWOOD TURNER exhibited *microscopical specimens* from a case of "*tubercular disease of the kidneys with tubercular meningitis.*" In one kidney, the pyramids and cortical structure was almost wholly destroyed, and the lining membrane of the calices thickened, ulcerated, and covered with caseous matter; the cavity of the pelvis contracted. In the other kidney a few tubercles were seen in the cortex. Cerebral symptoms had been noticed a week before admission,

ten days before death. The sections were taken from the kidneys and pia mater, and shewed adenoid growth in these parts.

Mr. Gilbert thought that there was such a thing as a scrofulous diathesis, in the sense that persons of a certain build and aspect were liable to scrofula. Whether glandular enlargement resulted from inflammation of skin or mucous membrane, or not, depended largely on the *kind* of inflammation. He thought painting with tincture of iodine useless ; but with the use of a liniment made of iodide of potassium and soap liniment, he had seen enlargement of glands disappear.

Dr. Turner thought that *cervical* glandular enlargements were especially frequent partly because absorption was more rapid in the throat, and the distance absorbed products had to travel was shorter. Mr. Treves's theory did not explain why scalp eruptions caused glandular enlargements. Irritation of the throat was very common, but caseous glands were not. Enlargement of the glands was not of necessity scrofulous.

Mr. Lucas agreed with Mr. Gilbert in his remarks upon diathesis, and with Dr. Turner as to throat inflammations. There were many sites for inflammation in the head and neck,—scalp, ear, teeth, tonsil, pharynx, larynx, nose, &c.,—and he believed this was the reason why enlarged cervical glands were so common. Freely discharging surfaces did not cause glandular enlargement. The descriptions of the scrofulous and other diatheses given by the old writers were imperfect, because many diatheses were mixed up together, *e.g.*, they had no knowledge of hereditary syphilis. There were many kinds of glandular enlargement. It was often chronic only, because it was kept up by local irritation.

Mr. Stevens thought that caseous glands sometimes prevented phthisis. He had known an instance in which one member of a family died from rapid phthisis, while another who had enlarged glands, lived long. He believed that bad feeding in infancy, and the exanthems, were important causes of scrofula.

Mr. TREVES in reply, pointed out that Mr. Lucas's explanation of the frequency of cervical gland disease, (as due to the number of those glands and the numerous sources of peripheral irritation,) could hardly be accepted as the sole or even principal explanation, inasmuch as it would scarcely adapt itself to the case of disease of the bronchial and mesenteric glands.

A Meeting of the Hunterian Society was held at the London Institution, on Wednesday, October 12th, 1881, Dr. P. L. BURCHELL, President, in the Chair.

Dr. Bedford Fenwick was elected an ordinary member of the Society.

The PRESIDENT addressed the Society, welcoming them back to their labours after the recess, and briefly bringing to their recollection the names and work of the members of the Society who had died since the last meeting :—Dr. A. Billing, Mr. Luke, both of whom had been Presidents of the Society, and Dr. Kingsford of Upper Clapton.

Mr. LUCAS exhibited a patient with her baby. The child was born in December, 1880. The mother was inoculated with syphilis about Easter, 1881; she had had well marked secondaries, and had been treated with mercury. She had suckled the child throughout. It

seemed perfectly healthy, never having had syphilitic symptoms of any kind.

Mr. Corner observed that in the mother's milk the child had imbibed the antidote (mercury,) as well as the poison.

Dr. Mackenzie said that some diseases, *e.g.*, bovine tuberculosis, were transmitted by milk.

Mr. Brownfield remarked on the analogous case of vaccine lymph, which did not transmit syphilis unless mixed with blood.

The President asked if it was possible for pure vaccine lymph, unmixed with blood, to communicate syphilis.

Mr. Hutchinson was sorry to say that there was proof that it could. He thought the immunity of the child shewn by Mr. Lucas was due to the digestion of the milk. The digestion destroyed the poison. A pig could eat a rattlesnake with impunity, although a bite from the rattlesnake would kill it.

Dr. Braxton Hicks said that possibly secondaries might yet appear in the child, they were sometimes late in development.

Mr. Gilbert said that he had found blood corpuscles present in vaccine lymph which was not altered in colour.

A paper was then read by Mr. HUTCHINSON, "*on the results of second inoculations in those who have had syphilis,*" of which the following is an abstract.

In order to remove sources of fallacy, the author first made some remarks on the remarkable proneness to herpes on the penis of those who had had chancres. These frequently recurring attacks of herpes were sometimes, he said, mistaken for fresh chancres, and they also rendered their subjects additionally liable to fresh infection. In some cases, herpetic sores might indurate and

become very difficult of diagnosis.

The paper next adverted to the recurring induration of true chancres, a phenomenon first described by himself, and upon which Fournier of Paris, two years later, had written an important paper. These relapses of induration usually occur in the site of the original sore, and might be observed at very varying periods after it. Sometimes many attacks at intervals of a few months or a year would happen to the same person. It was quite impossible to distinguish between the induration of a relapsed chancre and that of the original. In some instances relapses might be due to fresh infection, but in many they were unquestionably independent of it. They proved conclusively that specific induration was possible for a second time in those who had had syphilis, and before the effect of the first attack had passed by.

Cases of true second inoculation were next discussed under two heads ; 1st—Those in which a second chancre, indurated or not, is the sole result ; and 2nd—Those in which secondary symptoms also follow.

The author said that in collecting the facts for his paper he had been surprised to find in how small a number he was in a position to prove beyond doubt the occurrence of two bona fide attacks of syphilis, both attended with constitutional phenomena.

Cases of second chancres, well indurated, were fairly common, but in most no secondary symptoms resulted. In cases in which secondary symptoms were proved to have followed the second chancre, there was often doubt as to whether they had attended the first. The same remark had, he said, been made by Fournier. He nevertheless believed that it was possible to have syphilis twice with its full development of constitutional symptoms.

The particulars of cases were read, which he had carefully investigated, and believed to be examples of second and complete attacks. Usually, he thought, the second attack was much milder than the first.

Dr. Hamilton gave some further details as to one of the cases mentioned by Mr. Hutchinson, and narrated some cases of relapsing chancre.

Mr. Symonds described some cases of second indurated sores.

Mr. Lucas thought it was admitted that a second attack of syphilis was possible, but the statement that it might occur within 10 or 12 months, *i.e.*, while the syphilitic poison was still active, was new. He was doubtful whether these were not cases of recurrent chancre. Herpes of the penis occurred in persons liable to herpetic diseases, and it gave opportunity for syphilitic inoculation. He asked how could we be certain of the diagnosis of a relapsing chancre? Did it transmit syphilis?

Mr. HUTCHINSON knew of no case in which a relapsing chancre had communicated the disease. A second chancre did not imply a second attack of syphilis. In the case in which a second attack occurred in ten months, the diagnosis of the first indurated sore was open to question. A syphilitic gumma might resemble an indurated chancre. Relapsing chancres were not attended with glandular enlargement.

A Meeting of the Hunterian Society was held at the London Institution, on Wednesday, October 26th, 1881, Dr. P. L. BURCHELL, President, in the Chair.

Dr. G. W. Potter was elected a member of the Society.

Mr. G. J. B. STEVENS exhibited a tumour of the brain.

It was taken from a patient to whom he had been called on October 7th. She had 4½ years previously consulted a physician on account of headache. She was confined on September 3rd. She had otherwise been quite well till October 3rd, when she began again to complain of headache. On Mr. Stevens's arrival (October 7th) he found her in an epileptiform convulsion, affecting chiefly the right side. This was followed by coma, then another convolution, and then death.

A post mortem examination shewed a tumour occupying the whole of the left frontal lobe. It consisted of a cyst containing clear straw-coloured fluid, within which was a soft gelatinous growth.

A committee, consisting of Dr. Stephen Mackenzie, Dr. Turner, Mr. Lucas, and Mr. Stevens, was appointed to examine the tumour and report upon its structure.

Dr. Stephen Mackenzie remarked that the case shewed how comparatively well the brain bore gradual pressure as compared with sudden pressure. The seat of the growth corresponded to the distribution of the convulsive seizures.

Mr. STEVENS (in reply to Dr. Mackenzie) said that the eyes had not been examined, and (in reply to Mr. Fendick) that the headache was frontal. He attributed the absence of symptoms to the situation of the growth, the important parts at the base of the brain being unaffected, and he also thought the growth had not caused pressure till shortly before death.

Mr. JAMES ADAMS then read a paper on "*Wounds of arteries of the lower extremity.*" He first narrated a case of traumatic aneurism of the anterior tibial artery. The patient was a man aged 25, who cut himself with the edge (not the point) of a knife; the wound, about 3 inches in

length, extending from just below the tubercle of the tibia transversely downwards and outwards, reaching the fibula at about its middle. There was free bleeding at the time, but it was not thought that the artery was injured, and the wound was closed by sutures. In a day or two there was again haemorrhage, which was stopped by pressure. The wound healed in about a fortnight. When the patient began to walk about a tumour appeared. It was about the size of a hen's egg, with expansile pulsation and bruit. Treatment by rest and then by Esmarch's bandage produced no appreciable improvement, therefore it was determined to operate.

Under ether, with Esmarch's bandage applied, and with antiseptic precautions, the tumour was cut into and the clots turned out. On introducing the forefinger it passed through a hole in the interosseous membrane into an aneurismal cavity behind it full of loose clots. Mr. Adams had been careful, before operating, to examine the posterior aspect of the leg, having known of a case in which a punctured wound had gone through the interosseous membrane and wounded the posterior tibial artery; but no swelling was in this case perceptible in that situation. The hole in the interosseous membrane was big enough to admit the finger, and its edges were smooth. Mr. Adams therefore thought it had been produced by absorption from the pressure of the aneurism. Seeing that it would be difficult, without efficient drainage, to keep this posterior cavity empty, he made a free opening in the calf of the leg and put in a drainage tube as thick as the little finger. The vessel in front, which was found with little difficulty, was tied above and below. Convalescence was rapid; there was no constitutional disturbance and the drainage was perfect. Without "Listerism" and

drainage, Mr. Adams felt sure that a much longer time would have been required.

His second case was that of a man aged 65, whose urine contained both sugar and albumen. Twenty-three days before admission he had slipped in getting down a ladder, and strained his leg. Immediately after the accident he could walk, but for a week subsequently he was in bed with an illness said to be "congestion of the liver," the symptoms of which were obscure. On getting up, the leg was painful, and a popliteal swelling was observed, which had not been there before. The swelling and pain increased rapidly, and pulsation and bruit were observed. When admitted, the tumour filled the whole popliteal space, was doughy to the touch, very painful and tender, skin red and oedematous, and the leg below it oedematous. There was no pulsation, and only an uncertain bruit. Mr. Adams concluded that there was a diffused aneurism rapidly making its way to the surface. The unusual feature in the case was the absence of any history of a pre-existing true aneurism, or any injury which would account for a rupture of the vessel. He inclined to the belief that a small aneurism had existed there before and had given way. An exploratory incision was made, and the diagnosis as to its being a diffused aneurism being confirmed, the limb was amputated. On examining the part, a large cavity was found partially filled with loose clot, but no trace of a true aneurismal sac could be found, the blood being separated from the adjacent parts only by a loosely adherent soft limiting membrane. A hole, nearly as big as a threepenny bit, with rough everted edges, was discovered on the posterior aspect of the artery. The intima was very loosely attached and much thickened throughout, and there were considerable

patches of fibroid thickening. The case appeared to be one of ulcerative endocarditis going on to perforation. The condition of the artery in the neighbourhood illustrated well the absolute necessity of not attempting to secure the vessel near the point of aneurism or perforation, and a distal ligature must inevitably have led to gangrene.

Mr. ADAMS also exhibited a specimen from the London Hospital Museum, shewing a punctured wound of the superficial and deep femoral arteries, from which, owing to an abnormal distribution of the vessels, the patient bled to death in spite of ligature of both arteries above and below the bleeding points.

He also narrated a case, already published, of aneurism of the anterior tibial artery.

Dr. Turner said that cerebral hæmorrhage had been attributed to the rupture of aneurisms. He had found in such aneurisms fatty changes resembling those in Mr. Adams's second case. He had found great inflammatory thickening around such aneurisms.

Mr. Lucas spoke of the utility of Davy's lever for controlling the circulation through the femoral vessels. He intended to use it for aneurism. He had found it borne very well, as well on the right side as on the left. He thought torsion was far safer than ligature. Atheromatous arteries twisted very well, but must not be twisted too far.

Mr. Toulmin, Mr. Brownfield, Dr. Herman, Mr. Stevens also took part in the discussion, and Mr. ADAMS replied.

A Meeting of the Hunterian Society was held at the London Institution, on Wednesday, November 9th, 1881, Dr. P. L. BURCHELL, President, in the Chair.

A paper was read by Dr. ROBERT BARNES on "Antiseptic Midwifery" or "*Septicæmia in Midwifery*." The author began by pointing out that in some essential conditions septicæmia in puerperæ differed from septicæmia in ordinary surgical subjects. Simple septicæmia in puerperæ was an impossible thing. In pregnancy there were alterations in the blood, the heart and vascular system, the lymphatic system, the glandular system, and the nervous system. Then came labour, a sudden revolution, in which these conditions were suddenly changed. Absorption then took the place of nutrition and construction, the result being a rapid in-pouring into the blood of waste stuff. The condition of the blood thus brought about was not indeed septicæmia, for it was still within physiological bounds, but was perilously near to toxæmia. Unless the glandular and excreting organs could keep pace with absorption, waste stuff accumulated in the blood, which was thus poisoned, and we had fever, a form which might be called *endogenetic* puerperal fever. This was not septicæmia; and antiseptic treatment was powerless against it. By septicæmia the author meant that form of blood poisoning which arose from the absorption of foul stuff from the wounded genital canal. A remarkable fact in the history of reproduction was, that all the great steps in the process were attended with traumatism: (1) the ovary, (2) the hymen, (3) the utero-placental vessels, (4) the cervix uteri, (5) the perineum, all suffered injury. The surfaces of the wounds produced in labour were the gates by which poison from without

might enter the system. The lochia, bits of placenta or membranes, or clots, might decompose, and absorption of this stuff meant septicæmia ; but it was much more than ordinary septicæmia, in that the poison was taken into blood combining the characters of (1) the pregnant, (2) the puerperal state,—a triple compound of dangerous factors, each intensifying the dangers peculiar to the others. This was *auto-genetic* puerperal fever; the patient absorbing poisons of her own creation. It was grafted upon and included the endogenetic fever.

The conservative treatment of the puerpera Dr. BARNES summarized by saying that there were three things to do. (1) To shut the gate against the enemy by ensuring perfect contraction of the uterus ; to this end he gave a mixture of ergot, quinine and digitalis from the day of labour for a fortnight, and kept pressure on the uterus by means of a pad and binder. (2) To drive it away from the gates ; and (3) If any entry be effected into the system, meet the enemy there by quinia, aconite, and by chasing the poison through the uterus by intra-uterine injections of carbolic acid or iodine. These injections washed away the foul stuff from the uterus and genital canal, and they chased what entered into the blood, there acting as an antidote.

Mr. Fendick asked if the cervix was always torn ?

Mr. Stevens did not think tearing of the genital canal was so universal as Dr. Barnes appeared to hold. He asked whether treatment was wanted when the patient was doing well. In cases of peritonitis it was impossible to carry out the antiseptic measures Dr. Barnes had described. Sometimes the poison was conveyed by the practitioner in attendance ; he believed he had done so himself.

Mr. Gilbert questioned whether illness arose from natural processes alone. He had seen much puerperal fever. He had noticed it preceded by especially severe after-pains. Cases where the discharges were offensive or the foetus putrid, he thought, were more liable to it. He had seen one case in which the husband also suffered from diarrhoea and fever. He enquired whether members had seen benefit from sulphite of soda. He had as a rule seen no decided result from it, but in two cases he thought it had prevented puerperal fever.

Mr. Burton said parturition was a physiological action, and he thought the precautions described by Dr. Barnes were unnecessary; that patients would oppose their use; and that the pad and binder did more harm than good. He asked if Dr. Barnes's results had been better since he had used these precautions?

Dr. Fancourt Barnes said there were two classes of antiseptic precautions, those required in lying-in hospitals and those required in private practice. At the British Lying-in Hospital he had had the spray used in the lying-in room and over the vulva at the time of delivery, and the uterus and vagina had been syringed with carbolic acid during childbed. The results had been very good; pyrexia during the lying-in period, which before the introduction of these measures had been very common, had since been almost unknown. Such strict precautions were not necessary in private practice, but they could do no harm. He mentioned a case published by an Italian author, in which a man acquired puerperal fever from his wife.

Dr. Talbot King also thought hospital and private practice very different. He thought the proposed measures would be very irksome to the patient. He mentioned a

case of retained placenta in which neither decomposition nor septicæmic symptoms occurred.

Mr. Toulmin always gave ergot, and kept a pad on the uterus. He thought there was danger of prolapsus if the patient sat up too soon. He had used iodine as a disinfectant.

Mr. Corner thought most patients with puerperal fever were poisoned through the uterus or genital passage. He doubted whether puerperal fever was as common in primiparæ as in multiparæ. He had no doubt, from the astonishing benefit which followed washing out the uterus, of the effect of the foul matter in producing septic absorption. He had seen cases traceable to scarlet fever.

The President asked whether Dr. Barnes advised syringing the uterus in every case? He thought the distinction drawn by Dr. Fancourt Barnes and the results he had obtained very important. Excellent results had been obtained by using antiseptic precautions at the City Road Lying-in Hospital. Private patients could not be treated like hospital patients.

Mr. Brownfield had met with cases of puerperal fever in very hot weather. He asked whether this was the experience of others?

Dr. Herman thought labour a natural process only requiring treatment in exceptional cases. He thought lacerations were not invariable; he had examined women who said they had had children in whom the cervix presented no mark; and Dr. Matthews Duncan had recorded cases of multiparæ examined after delivery, in whom no injury to the soft parts could be detected. It had been shewn by experiment that the healthy lochia were capable if inoculated of producing inflammation and fever. He thought lacerations of the lower part of the

genital canal were more important as sources of infection than the placental site. He mentioned an epidemic of puerperal fever which had occurred in Germany and was apparently due to the routine syringing of the uterus. He had seen rapid benefit sometimes follow syringing, but oftener not. He thought a most important step which had yet to be taken, was to find means of diagnosis between *sapræmia*, in which the disease was due to putrid poison which did not multiply in the body and was cured when the putrid poison was washed away, and *septicæmia*, which was due to septic poison, which multiplied in the body, and therefore its effects did not cease when the uterus was washed out. He had seen puerperal fever in connection with scarlet fever in the same house. He referred to the excellent results obtained in some Paris hospitals by great cleanliness without the use of spray.

Dr. Galabin spoke as to the transference of poison by the medical attendant. He thought more reliance should be placed on antiseptics to prevent this than on lapse of time. Germs might adhere to clothes which could not be washed ; he thought great care should be taken by the accoucheur while examining a patient to prevent his clothes coming in contact with any secretion from the patient. He thought, nevertheless, that it was safer for a practitioner who was in attendance on a case of puerperal fever, to abstain from midwifery practice while doing so. He mentioned a case illustrating the utility of antiseptics. He had performed version in a case in which the discharges were very foetid, and the patient subsequently died with multiple abscesses. An hour afterwards he performed craniotomy, and the patient did well. He had seen one case in which he believed he had conveyed infection ; having scarlet fever at the time in his

own house, he had been obliged, in an urgent case, to remove an adherent placenta, and the patient died.

Dr. BARNES said that so long as the organs acted well and got rid of waste products there was no fever, and parturition was a physiological process. Traumatism at the placental attachment was invariable, and laceration of the cervix was nearly always present. Lacerations of cervix and of the perineum might heal without leaving any visible trace; he had seen this. The placental wound was the poison gate. Septicæmia was, he thought, less common in primiparæ. He did not use injections in every case; but he used the pad and thought it did good. He had only seen negative results from sulphite of soda, but he thought it was worth trying. He preferred iodine to carbolic acid, but thought sulphurous acid better than either. The form of puerperal disease caused by scarlatinal poison was different from those which he had described; it was *hetero-genetic*. He should himself have no fear, after proper disinfection, of transmitting contagion. In individual cases the source of infection could often only be traced by events. The indication for intra-uterine injections was a rise of temperature; in such cases their effect was often wonderful. He should not fear ill results from them. The hygienic state of the German lying-in hospitals was so bad that he should not be surprised at any results happening there.

A Meeting of the Hunterian Society was held at the London Institution, on Wednesday, November 23rd, 1881, Dr. P. L. BURCHELL, President, in the Chair.

Mr. G. W. Potter and Dr. Bedford Fenwick were admitted members of the Society.

Dr. PORT exhibited three patients who had been the subjects of "*Hydatid disease of the Liver.*" In each of the cases some time had elapsed since recovery had taken place.

1. G. King, aged 8, admitted into the German Hospital in January, 1880, with a tumour of the size of a small orange in the epigastric region. Two ounces of clear fluid containing echinococci were drawn off by an exploratory puncture. For three days subsequently there was rise of temperature, vomiting, and pain in the abdomen. As some weeks afterwards the tumour had got much larger, adhesions were produced by the insertion of several fine trocars, and then an incision was made. The cyst wall was discharged by suppuration, and recovery took place.

2. S. Rosenfeld, aged 26, admitted January, 1880, with a tumour of the size of a foetal head in the epigastric region. Four fine trocars were introduced, and the canulas left in position for several days. Although only a few ounces of a clear liquid had been abstracted the tumour decreased in size, and therefore no incision was made. The patient at the present time shews no signs of the tumour formerly present.

3. Marie Mendel, aged 30, was admitted in February, 1879, with a large nodulated tumour in the epigastrium. Only a few ounces of clear fluid could be withdrawn by an exploratory puncture. This was followed by febrile disturbance and urticaria. The tumour decreased in size very slowly, and the last remains of it disappeared only at the beginning of the present year, during pregnancy.

After giving a short description of the nature of the disease, Dr. Port discussed the different modes of treatment.

He was of opinion that these tumours should not be

left to themselves, although cases of spontaneous cure had undoubtedly occurred. He did not expect any good from medicinal treatment, and would not recommend iodide of potassium. Some operative procedure was therefore the only thing that remained.

The author described the usual method, which consisted in inserting a fine trocar, abstracting more or less of the cyst contents, and withdrawing the canula. He did not think that, even with the greatest care, the entrance of some of the liquid into the peritoneal cavity could be avoided. He admitted, however, that in many of the recorded cases the simple puncture had led to recovery. In Nos. 2 and 3 of his own cases the abstraction of part of the cyst contents had brought about the disappearance of the tumour. The question remained whether this was final. Dr. Harley reports cases where patients stated to be cured presented themselves 5 or 10 years afterwards with a full re-development of the disease. In this author's opinion the cure can be certain only if the cyst walls have been thrown off together with the contents, *i.e.*, after suppuration.

Simon introduced several fine trocars into the most prominent part of the tumour, closed the canulas with little plugs, and left them in position for several days. Firm adhesions being in this way produced between the cyst wall and the abdominal parietes, a free incision could be made if necessary.

The advantages of this method are :

1. The first step in the operation gives the opportunity for verifying the diagnosis.
2. As the canulas remain in position, an escape of the cyst contents into the peritoneal cavity will not easily take place.

3. The chief advantage is this: that during several weeks one is quite at liberty either to make an incision or to wait for the spontaneous absorption of the cyst.

Mr. Lucas had known a patient with a cerebral tumour, shewn by autopsy to be hydatid, take iodide of potassium for a long period without any effect. Ovarian tumours sometimes resembled hydatid tumours. He had known hydatid tumours taken for ovarian cysts. He thought tapping was usually successful, but had seen a case in which the symptoms recurred; possibly in this case there was more than one cyst. Escape of hydatid fluid into the abdomen, he thought, usually caused some disturbance. He had known electrolysis tried with success, but some of the fluid escaped into the serous cavity, and therefore the cure may have been really due only to the tapping. The operation of puncture was not free from risk; he had known a case in which the needle penetrated the portal vein, and instant death followed.

Dr. Mackenzie, with reference to the recurrence of the disease after tapping, said the tumour was only usually, not invariably, single. Puncture was usually successful. A fine trocar should be used; he had lately employed the aspirator. He had seen one fatal case after tapping. He enquired if Dr. Port had seen the disease known as "multilocular hydatids." It was described by continental writers, but never seen in England. The diagnosis of a suppurating hydatid cyst was most difficult. Sometimes the contents were expectorated through the lung, which was usually an unfavourable termination. Drug treatment was quite futile.

Dr. Herman pointed out that the disease was due to the growth of a living parasite. If this parasite were once

killed, it was extremely unlikely that it would come to life again.

Dr. Lichtenberg said the best treatment was to open the sac after adhesions had been formed. He mentioned that Professor Volkmann opened the abdomen over the liver, and stuffed the wound with gauze, thus procuring adhesions, and then opened the tumour.

Dr. Bedford Fenwick thought that adhesions could be diagnosed by the absence of descent of the liver during inspiration. He had seen the diagnosis so made verified by post mortem examination. He had often seen adhesions, post mortem, where no interference had been resorted to to produce them.

Dr. PORT in reply said he had never seen "multilocular hydatids." He would not altogether trust to the inference drawn from the movement of the liver during inspiration.

A Meeting of the Hunterian Society was held at the London Institution, on Wednesday, December 7th, 1881, Dr. P. L. BURCHELL, President, in the Chair.

A paper was read by Dr. FRANCIS WARNER on "a case of Empyema treated antiseptically."

The patient was a healthy woman, 30 years of age. She was admitted in the second week of an attack of pleuritic effusion of the right side. Dyspnœa, cough, and want of sleep necessitated tapping; 25 ounces of serum were drawn off; relief followed. In the 9th week of illness, the effects of the effusion being distressing and temperature averaging 100 to 102°, tapping was used again, and 23 ounces of pus were removed with some relief. Again, in the 11th week, 52 ounces of pus were

removed. Fever continuing, the pus having reaccumulated and the patient being no better, Mr. Couper operated with antiseptic precautions, the patient being under the influence of ether. One tube was inserted under the angle of the scapula, the other under the nipple. From this time all fever subsided, no reaccumulation of pus occurred, and the patient had no ill symptoms. The antiseptic dressings were changed in all 51 times. Six months from outset of illness the patient was well again at her household work. She is now at the end of the second year of convalescence and strong and well.

The spine is quite straight, the right chest a little smaller than the left but not deformed.

Remarks by Dr. WARNER:—The favourable result was attributed to the free drainage of the pleural cavity after suppuration with antiseptic precautions. It was also thought that drainage without irrigation was most favourable when possible. The advantages of the operation were considered to lie in the complete drainage afforded by the two tubes, the one allowing ingress of air to the pleural cavity, while pus escaped by the other, thus the movements of the chest do not move the lung. Rest to the lung was considered an important benefit resulting from free admission of air to the cavity of the pleura; rest was also considered to favour expansion of the lung by a process of granulation.

Mr. Corner, alluding to a remark of the author that respiration was heard behind, near the spine, though 52 ounces of fluid were soon after withdrawn, said that he believed this to be the rule and not the exception. He thought it advisable to operate early and to syringe out the cavity with weak carbolic lotion.

Mr. Stevens had a case of empyema which was drained

and did well. A persistent high temperature, say of 103°, was an indication that the effusion was becoming purulent.

Mr. Rivington, after ten years as Surgeon to the London Hospital, had not met with a single case in that institution, and this he attributed not to the absence of cases in the medical wards, but to the tendency of the Physicians of this institution to treat the cases by the aspirator, without consulting the Surgeons. He thought vertical drainage might be better than transverse.

Mr. Clement Lucas said that the Physicians at Guy's Hospital treated the Surgeons more courteously. He had known a great many cases successfully treated by drainage. Formerly it was the custom to attempt to exclude air by allowing the drainage tube to drop into a jug or bottle of water, but this had been given up since antiseptic dressings had been introduced. It was now his practice after introducing the tube to cut it quite short and cover it with antiseptic dressings.

Dr. Fotherby asked if medical treatment had been adopted before the first aspiration; to which Dr. WARNER replied that full doses of quinine and iodide of potassium had been given.

A Meeting of the Hunterian Society was held at the London Institution, on Wednesday, January 11th, 1882, Dr. P. L. BURCHELL, President, in the Chair.

Mr. F. J. Bottomley, Mr. G. H. W. Thomas, and Dr. J. S. E. Cotman, were elected members of the Society.

A paper was then read by Dr. P. H. PYE-SMITH on "*the pathological significance of pus in the urine, and the*

treatment of suppuration in the kidney," of which the following is an abstract.

The author began with a reference to the methods of detecting small quantities of pus in the urine, and to the significance of pus being found associated with mucus, blood and phosphates respectively, and also to the diagnostic value of the purulent urine being acid or alkaline, and of the flow of pus being constant or intermittent.

He then proceeded to discuss, first—the symptoms which are of value in localizing the seat of suppuration in the bladder, the kidney, the prostate, or an abscess opening into the urinary tract; and next—those which enable us to determine the origin of the suppuration, in a local injury, a calculus, or gravel of the kidney or bladder, in tubercular ulceration (often associated with disease of the epididymis) in new growths of the urinary tract, in the pressure of parasites, in inflammation due to obstruction, in extension of gonorrhœa to the bladder, or lastly in catarrhal pyelitis or cystitis arising in the course of gout, of diseases of the spinal cord, and from idiopathic (*i.e.* unknown) causes.

From a series of 27 cases illustrative of these observations, the following were then shortly referred to. Two cases of abscess opening into the bladder, one from the prostate, the other from the neighbourhood of the cæcum. One of a large hydatid cyst, discharging per urethram, with profuse pyuria, and ending (like the two preceding cases) in recovery. Two of villous tumour of the bladder, both in female patients, one in a child of 5 years old. One case of suppuration of the kidney, caused by obstruction of the ureter by inflammation due to a kick from a horse. Two of suppurative pyelitis which ended in

complete recovery after opening the abscess from behind. One of (probably tubercular) suppuration in a floating kidney. One in which bacteria were found in the urine as passed, without previous catheterisation.* Three cases of cystitis occurring in the course of insular cerebro-spinal sclerosis.

The paper concluded with a brief examination of the methods of treating the several conditions described, especially by means of diluents, of diet, of acids, of alkalies, and of sedatives; the supposed specific action of sulphide of calcium in checking suppuration; the use and abuse of the catheter and of injections into the bladder; and the propriety of operative interference in cases of suppuration of the kidney due to a calculus. Several recent cases of operation in this condition were quoted from Mr. Durham, Mr. Lucas, Mr. Morris, and Mr. Barker; and the belief was expressed that the resources of modern surgery will make nephrotomy a frequent and in three-fourths of the cases a successful operation.

Mr. Lucas gave some further details as to the cases of villous growth. He mentioned one which he had seen long ago, and in which, were it to come under his care now, he would cut into the bladder. He mentioned some cases in which pyuria had been taken for cystitis. He had tried calcium sulphide in cases of glandular abscess, and had found it useless. The patient whose kidney he had excised was still alive.

Dr. Herman said he believed the diagnosis of renal disease, more particularly the decision which kidney was involved, might be greatly be helped by catheterizing the ureters. He had himself passed a sound into the ureter, and thought that a flexible catheter might be passed up

* Compare Dr. William Roberts's cases in his paper read at the late International Medical Congress.

to the pelvis of the kidney and the urine withdrawn and examined. He spoke of the ease and advantage of dilating the urethra in the female, by which not only the bladder could be explored, but cystitis was almost invariably relieved and he thought sometimes cured. He mentioned a case in which cystitis had followed ovaritis, probably by extension.

Mr. Corner spoke of the severe suffering which stone in the kidney caused, and which had hitherto been incapable of relief; the advance of surgery here was most encouraging. He mentioned a case in which he had tapped, emptied and washed out a renal cyst, and the patient perfectly recovered. He thought it quite justifiable to sound the kidney. He had seen a severe case of irritable bladder, possibly due to masturbation, in which he thought an exploratory incision into the bladder would have been quite justifiable.

Mr. Stevens mentioned a case in which he believed that gonorrhœa had been the predisposing cause of cystitis and pyelitis, the exciting cause having been a fall. The patient recovered. Pressure on the kidney appeared to be very beneficial.

Dr. PYE-SMITH had not seen pyelitis from gonorrhœa except after cystitis, but he had seen it secondary to strumous epididymitis. With villous growths hæmaturia usually preceded the appearance of pus. He thought that to find out the condition of one kidney it would be enough to occlude the opposite ureter with the sound. In the case of cystitis following ovaritis, he should think it more probably from nervous sympathy than from direct extension. He had seen a case in which the kidney had been incised without any bad result, but he did not think it would be well to lay open tuberculous kidneys.

A Meeting of the Hunterian Society was held at the London Institution, on Wednesday, January 25th, 1882, Dr. P. L. BURCHELL, President, in the Chair.

Mr. J. S. E. Cotman and Mr. G. H. W. Thomas were admitted members of the Society.

Mr. Robert Bruce, jun., and Mr. Arthur Greenwood were elected members of the Society.

A paper was read by Dr. CARRINGTON on "*Two cases of hepatic suppuration, associated with dysentery,*" of which the following is an abstract.

The specimens were examples of the two forms of suppuration of the liver met with in practice. One was a case of ordinary tropical abscess. This patient was admitted into the Seamen's Hospital, moribund, with a large tympanitic swelling under the right ribs. He died soon after admission, and three large abscesses were found in the liver, together with early dysenteric ulceration of the large intestine. The other patient was a lighterman engaged on the Thames, who had never left this country. He was admitted with obscure febrile symptoms, and the case for some time presented considerable difficulty in diagnosis, somewhat simulating typhoid fever. Subsequently, however, an abscess in the liver was detected, and operated upon by Mr. Johnson Smith. There was a temporary improvement in his condition, but this was not maintained, the man dying after about seven weeks illness. The post mortem shewed the liver full of small abscesses of about the size of a hazel nut or smaller. In many spots the change had not gone so far as suppuration, and there were either localized patches of hyperæmia, or points at which the hepatic substance was greyish black, surrounded by a zone of vascularity. The large intestine

was sloughy and gangrenous, but in points exhibited early dysenteric ulceration.

The first case was interesting, in that the early stage of the intestinal ulceration suggested that the abscesses in the liver were of date anterior to it.

The second case was of clinical importance, both from its close resemblance in many points to enteric fever, and also as being an example of undoubted dysentery in a man who had never been abroad.

The relation of dysentery to hepatic abscess was then discussed, and the bearing of the cases upon this disputed question adverted to. The first case appeared to be one in which the affection of the liver occurred before that of the intestine. In the second case the abscesses appeared to be clearly of embolic nature ; the source of possible emboli was gangrenous, and the patches in the liver were rather patches of local gangrene followed by surrounding suppuration, than abscesses from the first. That the abscesses in multiple suppuration of the liver do not run into one another and produce the solitary tropical condition appeared to be shewn by the notes of six cases of multiple abscess from the post mortem records of Guy's Hospital, in all of which the livers were riddled with small abscesses, none larger than a hazel nut, and most of them of the size of a pea ; the cases having lasted 60, 63, 42, 42 and 79 days respectively ; the sixth being the second of the cases now brought before the Society. On the other hand it was stated, on the authority of Dr. Murchison, that an enormous tropical abscess might form in a fortnight.

Dr. Mackenzie said that the case illustrated the different forms of hepatic abscess, of which there were four :—(1) the traumatic ; (2) the hydatid ; (3) the portal,

from purulent inflammation in the territory of the portal vein. This form was not met with in all kinds of intestinal ulceration, *e.g.* it was rare in typhoid fever. (4) The tropical; this might exist without dysentery. Scorbutic dysentery did not cause abscess; malarious dysentery did. Probably the infection of the second case was arterial. In such cases there was great difficulty in the diagnosis from typhoid fever. Tropical abscess did occur in England, which was a point in favour of the view that malarious dysentery might also do so.

Dr. Turner mentioned a case of hepatic abscess from injury, with dysenteric symptoms. There was an abscess between the liver and the diaphragm, burrowing into the liver, and considerable ulceration of the colon. He thought there was reason to think that the abscess might have caused the ulceration, although it was difficult to explain how. Septic matters might have got into the intestine from the liver. The colon was more liable to ulceration than the small intestine, because its contents were more liable to impaction; the cæcum was especially liable from this cause. This explained why ulceration of the small intestine did not usually cause hepatic abscess.

Dr. CARRINGTON, in reply, said that in his case the infarcts in the spleen were not sloughing as were those in the liver. It might be that they were thrombotic and those in the liver embolic. He thought Dr. Turner's case was one of a different class from those he had narrated.

Dr. TURNER exhibited *microscopic specimens* shewing "*miliary aneurisms of the cerebral arteries.*" They had been obtained from the body of a female aged 53, who had died from cerebral haemorrhage. They illustrated the views of Charcot and Bouchard upon the cause of that affection. The microscopical preparations shewed many

cerebral arterioles on which minute aneurisms had formed. Under the microscope these vessels were seen to be affected by the peri-arteritis described by the French observers, both in its early and active and in its later or sclerotic stage. The vessels shewed also an advanced degree of atheromatous and, some of them, also calcareous changes in their inner and middle coats. The aneurisms were quite independent of these latter pathological conditions.

Dr. Mackenzie said that the theory of Charcot and Bouchard as to the occurrence of cerebral haemorrhage from miliary aneurisms had not yet been actually verified. Dr. Turner's specimens were most valuable evidence on the point. He agreed with the description Dr. Turner had given of his specimens. Possibly arterial sclerosis was a change not wholly without benefit.



